STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012278	A. BUILDING _____ B. WING _____	10/05/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADVANCED AMBULATORY SURGERY CENTER LLC	1101 PROFESSIONAL BLVD STE 104 EVANSVILLE, IN 47714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for an Initial State Licensure Survey. Date of Survey: 10-5-11 Facility Number: 012278 Surveyor: Billie Jo Fritch, RN, BSN, MBA Public Health Nurse Surveyor Advanced Ambulatory Surgery Center, LLC is in compliance with 410 IAC 15-2, Ambulatory Surgery Center Licensure Rules. QA: claughlin 10/21/11	S 000		